Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health and Associates

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-14-1424-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are the referring HCP and we are billing for case management services. …Neva Vida obtained preauthorization for 6 sessions of individual psychotherapy on 4/17/2013."

Amount in Dispute: $461.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Hartford upholds denial of the disputed dates of service."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2013 through September 9, 2013	99361, 90837	$461.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 167 – This (these) diagnosis(es) is (are) not covered
   - 269 – This billing is for a service unrelated to the work illness or injury
   - 247 – A payment or denial has already been recommended for this service
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date
   - 556 – This provider is not an authorized treater in workers compensation
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

- 293 – This procedure requires prior authorization and none was identified

Issues

1. Did the requestor resolve the dispute for work related illness or injury?
2. Do the services in dispute require prior authorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied dates of service June 10, 2013 and September 9, 2013 based on denial reason code "269 – This billing is for a service unrelated to the work illness or injury," during the medical bill review process. The dates of service referenced above contain unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, dates of service June 10, 2013 and September 9, 2013 were not considered in this review.
2. Per 28 Texas Administrative Code §134.600(p)(7) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;" Review of the submitted documentation finds two "Request for certifications" from the Hartford. The first dated April 17, 2013 has a start date of 4/17/2013 and End date of 06/17/2013. The approved service is for CPT code 90834, Authorization number 1318740 for 6 visits over 6 weeks. The second has a Start date of 04/17/2013 and End date 08/17/2013, approved service is for CPT code 90834, Authorization number 1318740 for 6 visits over 6 weeks. The carrier denied the submitted charge for July 29, 2013, August 5, 2013 and August 8, 2013 as "15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider." The submitted CPT code on the medical bill was 90837. The authorized CPT code from the carrier was 90834. The services in dispute were not authorized; the carrier's denial is supported.
3. Review of the submitted documentation finds that per Division rules and guidelines no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.